STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Residential Health Care Facility in McPherson, Kansas on 3/15/16, 3/16/16, and 3/17/16. Amended 2567 sent to facility 3/22/2016	S 000		
S 230 SS=E	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(c) The census equalled 13 the sample included three Residents. Based on interview and review of record, for two of three sampled (#189 and #187), the Operator failed to ensure the	S 230		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S 230	Continued From page 1	S 230		

implementation of facility policies and procedures that specified if a Resident has an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive. in the medical record.

Findings included:

- Review of record revealed #187 admitted to facility 10/05/15 with diagnoses of Diabetes II, Hypertension, Cerebrovascular accident with Left side hemiparesis, and Multi - infarct dementia.

The electronic medical record Resident profile page documented "Full Code."
A notation at the bottom of each MAR (medication administration record) from October 2015 to March 2016 notated "DNR" (do not resuscitate).
A paper list of Resident names taped inside the main kitchen cupboard, for immediate staff reference in the event of an emergency, documented #187 as "DNR".
The medical record lacked a DNR form, complete with Resident/Legal Representative or physician signature.
The medical record lacked a legal document to indicate this directive discussed and actually the wishes of the Resident.

On 3/15/16 at 2:00pm, Facility Licensed Nurse #C confirmed no copy of a DNR document available in the medical record, or at the main office in process of being scanned.

On 3/16/16 at Operator/RN (registered nurse) #B confirmed no copy of an advanced directive for DNR available... stated that designation most likely on bottom of MAR because the MAR was a template copy...

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S 230	Continued From page 2 Operator/RN #B provided copy of information given to Resident at time of admission. This page titled Advance Directives specified facility has policies to ensure Resident wishes followed (item III)... and specified the facility to maintain a copy of any advanced directive in Resident's record (item IV). The Operator/RN failed to ensure the implementation of facility policies and procedures that specified if #187 had an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive in the medical record. - Review of record revealed #189 admitted to facility 01/25/11 with diagnoses of Diabetes II and Dementia. The medical record Resident profile page documented "DNR." The medical record contained forms (negotiated service agreements, service agreements, etc) signed by persons other than the Resident. Initially, unable to locate the DNR form signed by Resident and physician. On 3/16/16 at 10:16am, Operator/RN (registered nurse) #B confirmed #189 has a "DNR" a DPOA (durable power of attorney) and a DPOA for Healthcare. #B able to locate the "DNR" form. The medical record still lacked the DPOA and DPOA for Healthcare documents. #B contacted family members and requested these be faxed immediately to facility. On 3/16/16 at 1:40pm, Operator/RN #B confirmed the DPOA and DPOA for Healthcare arrived by fax.	S 230		

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S 230	Continued From page 3 The Operator/RN failed to ensure the implementation of facility policies and procedures that specified if #187 had an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive in the medical record.	S 230		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d)(1)(4) The census equalled 13 the sample included three Residents. Based on observation, interviews, and reviews of record, for two of three sampled (#187 and #185), the Operator failed to ensure the review and if necessary revision of each negotiated service agreement (NSA) if requested by the Resident or the Resident's family, or by facility staff.	S3092		

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S3092	Continued From page 4 Findings include: - Review of record revealed #187 admitted to facility 10/05/15 with diagnoses of Diabetes II, Hypertension, Cerebrovascular accident with Left hemiparesis, and Multi-infarct dementia. The current 10/06/15 functional capacity screen (FCS) assessed #187 in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; unable to manage medications and treatments; with cognitive impairment; with falls and with wandering. The current 10/06/15 negotiated service agreement (NSA) documented #187 to receive services to address these needs from facility. Inter Office Communication (IOC) notes of record revealed: 10/10/15 - 10:46am - late entry from 10/09/15 had non injury fall around 1030... was trying to get up from recliner... slid off end of foot rest... 10/29/15 - 9:17am - patient has 2 falls the morning of 10/28/15 home health nurse came and assessed resident on both falls...combative when staff assisting... 11/02/15 - 3:28pm - Resident had 3 falls since interventions last reviewed... meeting with family... reinforced with #187 importance of using call light to ambulate or transfer... reviewed with staff motion alarm to be on at all times 12/06/15 - 11:47pm - had fall on 12/05/15 fall interventions reviewed, will now have pressure pad under him/her at all times to help prevent	S3092		

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S3092	Continued From page 5 future falls 02/13/16 - 4:08pm - follow up from fall on 02/12/16... assessment completed... no complaints of pain... discussed importance of waiting for staff assistance... 02/29/16 - 4:59pm - Resident had fall on 02/27/16... see home health chart for fall assessment and fall follow up Review of the NSA revealed the added interventions of a motion alarm on 11/02/15, a pressure pad underneath on 12/06/15, and ongoing education about waiting for assistance, not on the current NSA. The medical record lacked any NSA addendums. On 3/16/16 at 1:55pm, Operator/RN (registered nurse) #B confirmed the NSA lacked revision or addition of newly planned interventions to address ongoing falls. The Operator failed to ensure the review and revision of the NSA for #187 when changes in care needs prompted changes in services. - Review of record revealed #185 admitted to facility admitted 01/07/16 with diagnoses of Congestive heart failure, History of falling, Vascular dementia with behavior disturbances, and Malignant neoplasm of prostrate. The current 01/07/16 functional capacity screen (FCS) assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; unable to manage medications and treatments; with cognitive impairment; and with falls.	S3092		

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S3092	Continued From page 6 The current 10/06/15 negotiated service agreement (NSA) documented #185 to receive services to address these needs from facility. Inter Office Communication (IOC) notes of record revealed: No entries or documentation for admission of Resident to facility. 01/11/6 - 2:44pm - follow-up from fall on 01/10/16... assessment completed... treatment provided... staff education on checking Resident more frequently when in bed and using pressure pad, and responding to alarm in timely manner... Resident education on using call light and waiting for staff assistance before standing or ambulating... 01/12/16 - 01:20pm - follow-up from fall on 01/09... was sitting in wheelchair...confused... unable to answer questions appropriately... 01/13/16 - 4:16pm - call placed to physician in regards to Resident fall... awaiting return call at this time... 01/19/16 - 4:15pm - patient had two falls during night shift... Resident assessed... bruised area noted... family notified... staff educated on increasing checks on Resident while in bed to every 15 minutes... 01/19/16 - 4:22pm - fall interventions reviewed, new interventions put into place due to Resident's recent falls... Review of the NSA revealed the interventions of a pressure pad and alarm, and staff responding in	S3092		

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S3092	Continued From page 7 timely manner on 01/11/16, every 15 minute checks while in bed and other new interventions added on 01/19/16, not on the current NSA. The medical record lacked any NSA addendums. On 3/16/16 at 1:55pm, Operator/RN (registered nurse) #B confirmed the NSA lacked revision or addition of newly planned interventions to address ongoing falls. The Operator failed to ensure the review and revision of the NSA for #185 when changes in care needs prompted changes in services.	S3092		
S3228 SS=F	26-41-205 (l) (3) Medication Regimen Review Record (l) (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident ' s clinical record. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(3) The census equalled 13 the sample included three Residents. Based on reviews of records and interviews, for all residents, the Operator/RN failed to ensure the medication regimen reviews kept in each Resident's clinical record as evidenced by review two of two sampled (#189 and #187) residents with medication regimen reviews. Findings included:	S3228		

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S3228	Continued From page 8 - By review of Resident Roster, all Residents of facility received medication and treatment management services. - By interview on 3/16/16 at 10:29am, Operator/RN (registered nurse) #B stated the consultant pharmacist comes to facility every three months... pharmacist sends me an email after each visit that lists which Residents reviewed, and a general recap of his/her findings... confirmed nothing in individual charts unless specific recommendations made to physician (variance reports)... stated pharmacist reviewed medications of all Residents 12/23/15, email report includes names of all Residents reviewed but nothing for the individual medical records provided. #189 admitted to facility 01/25/11 with diagnoses of Diabetes II and Dementia. 9/09/15 functional capacity screen (FCS) assessed #189 unable to manage medications and treatments. 9/09/15 negotiated service agreement (NSA) documented #189 to receive these services from facility. #187 admitted to facility 10/05/15 with diagnoses of Diabetes II, Hypertension, Cerebrovascular accident with Left hemiparesis, and Multi-infarct dementia. 10/06/15 functional capacity screen (FCS) assessed #187 unable to manage medications and treatments. 10/06/15 negotiated service agreement (NSA) documented #187 to receive these services from facility. By review, each of these records lacked an	S3228		

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S3228	Continued From page 9 individual drug regimen review. For all residents , the Operator/RN failed to ensure the medication regimen reviews kept in each resident's clinical record.	S3228		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The census equalled 13 the sample included three Residents. For three of three sampled (#189, #187, and #185) the Operator failed to ensure each Resident record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action. Findings included: - Review of record revealed #189 admitted to facility 01/25/11 with diagnoses of Diabetes II and Dementia. The current 9/09/15 functional capacity screen (FCS) assessed #189 in need of physical assistance with bathing, dressing, toileting,	S3261		

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S3261	Continued From page 10	S3261		

transfers, and mobility; unable to manage medications and treatments; with cognitive impairment.
The current 9/09/15 negotiated service agreement (NSA) documented #189 to receive services to address these needs from facility.

Inter Office Communication (IOC) notes of record revealed:

03/15/16 - 12:55pm - Resident had a non injury fall this AM, see HH (home health) for assessment, family notified 0809 via phone call, physician notified via fax
The medical record lacked documentation of date and time of occurrence, lacked documentation of an assessment of the area... the record lacked action taken, and results of the actions taken.

On 3/16/16 at 11:15am, Operator/RN (registered nurse) #B confirmed the medical record lacked details to include time of occurrence, who discovered #189, alleged or determined cause of fall, actions taken, and results of the actions taken.

The Operator/RN failed to ensure #189's record contained documentation of all incidents, the date, time of occurrence, action taken, and results of the action.

- Review of record revealed #187 admitted to facility 10/05/15 with diagnoses of Diabetes II, Hypertension, Cerebrovascular accident with Left hemiparesis, and Multi-infarct dementia.

The current 10/06/15 functional capacity screen (FCS) assessed #187 in need of physical assistance with bathing, dressing, toileting,

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S3261	Continued From page 11	S3261		

transfers, and mobility; unable to manage medications and treatments; with cognitive impairment; with falls and with wandering.

The current 10/06/15 negotiated service agreement (NSA) documented #187 to receive services to address these needs from facility.

Inter Office Communication (IOC) notes of record revealed:

10/10/15 - 10:46am - late entry from 10/09/15 had non injury fall around 1030... was trying to get up from recliner... slid off end of foot rest...

10/29/15 - 9:17am - patient has 2 falls the morning of 10/28/15 home health nurse came and assessed resident on both falls...combative when staff assisting...

11/02/15 - 3:28pm - Resident had 3 falls since interventions last reviewed... meeting with family... reinforced with #187 importance of using call light to ambulate or transfer... reviewed with staff motion alarm to be on at all times

12/06/15 - 11:47pm - had fall on 12/05/15 fall interventions reviewed, will now have pressure pad under him/her at all times to help prevent future falls

02/13/16 - 4:08pm - follow up from fall on 02/12/16... assessment completed... no complaints of pain... discussed importance of waiting for staff assistance...

02/29/16 - 4:59pm - Resident had fall on 02/27/16... see home health chart for fall assessment and fall follow up

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S3261	Continued From page 12 On 3/16/16 at 1:55pm, Operator/RN (registered nurse) #B confirmed the medical record lacked details to include times of occurrences, who discovered #187, alleged or determined causes of falls, actions taken, and results of the actions taken. The Operator/RN failed to ensure #187's record contained documentation of all incidents, the date, time of occurrence, action taken, and results of the action. - Review of record revealed #185 admitted to facility admitted 01/07/16 with diagnoses of Congestive heart failure, History of falling, Vascular dementia with behavior disturbances, and Malignant neoplasm of prostrate. The current 01/07/16 functional capacity screen (FCS) assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; unable to manage medications and treatments; with cognitive impairment; and with falls. The current 10/06/15 negotiated service agreement (NSA) documented #187 to receive services to address these needs from facility. Inter Office Communication (IOC) notes of record revealed: No entries or documentation for admission of Resident to facility. 01/11/6 - 2:44pm - follow-up from fall on 01/10/16... assessment completed... treatment provided... staff education for prevention of further falls...	S3261		

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S3261	Continued From page 13 01/12/16 - 01:20pm - follow-up from fall on 01/09... was sitting in wheelchair...confused... unable to answer questions appropriately... 01/13/16 - 4:16pm - call placed to physician in regards to Resident fall... awaiting return call at this time... 01/19/16 - 4:15pm - patient had two falls during night shift... Resident assessed... bruised area noted... staff educated... On 3/16/16 at 11:40am, Operator/RN (registered nurse) #B confirmed the medical record lacked details to include times of occurrences, who discovered #185, alleged or determined causes of falls, actions taken, and results of the actions taken. The Operator/RN failed to ensure #185's record contained documentation of all incidents, the date, time of occurrence, action taken, and results of the action.	S3261		